ADD A PERSON FORM

SECTION 1

1 APPLICANT NAME	HOME PHONE	WORK PHONE	MESSAGE PHONE

2 FAMILY MEMBER NUMBER											

Please fill out this form for any person you would like to add to Healthy Families. To add more than 4 people, make a photocopy of this form. If a pregnant woman is within 90 days of her expected delivery date, she may apply to add her unborn child to Healthy Families. Coverage for the unborn child will begin 13 days after Healthy Families receives documentation of the baby's birth.

SECTION 2	Person 1 (or unborn)	Person 2	Person 3	Person 4
3 Name: Last				
First				
Middle				
4 Birthname: Last				
(if same as #3 above, leave blank) First				
Middle				
5 If the person's address is NOT the same as the Applicant, give address	Street City ZIP	Street City ZIP	Street City ZIP	Street City ZIP
6 Relationship to Applicant:				
7 Sex:	❑ **Male** ❑ **Female**	❑ **Male** ❑ **Female**	❑ **Male** ❑ **Female**	❑ **Male** ❑ **Female**
8 Date of Birth (or estimated date of delivery)	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR	/ / MO DAY YEAR
9 Place of Birth: **Calif. County, State or Country**				
10 Ethnicity Code				

1	White	**2**	Hispanic	**3**	Black/African American	**4**	Asian
5a	American Indian	**5b**	Alaska Native	**7**	Filipino	**A**	Amerasian
C	Chinese	**H**	Cambodian	**J**	Japanese	**M**	Samoan
N	Asian Indian	**P**	Hawaiian	**R**	Guamanian	**T**	Laotian
V	Vietnamese	**K**	Korean	**Z**	Other		

11 U.S. Citizen or National? If no, please write date of entry into U.S.	❑ **Yes** ❑ **No** / / MO DAY YEAR	❑ **Yes** ❑ **No** / / MO DAY YEAR	❑ **Yes** ❑ **No** / / MO DAY YEAR	❑ **Yes** ❑ **No** / / MO DAY YEAR
12 Social Security # *(optional)*	- -	- -	- -	- -
13 Mother's Name: Last				
(required for children) First				
Does the mother live in the home?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**
14 Father's Name: Last				
(for children) First				
Does the father live in the home?	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**	❑ **Yes** ❑ **No**

SECTION 2 CONTINUED	Person 1 (or unborn)	Person 2	Person 3	Person 4
15 Does this person have no-cost Medi-Cal? If yes, give date coverage will end.	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR	❑ Yes ❑ No / / MO DAY YEAR
16 Does the person have any health care coverage? If "yes," what kind?	❑ Yes ❑ No ❑ Health ❑ Vision ❑ Dental	❑ Yes ❑ No ❑ Health ❑ Vision ❑ Dental	❑ Yes ❑ No ❑ Health ❑ Vision ❑ Dental	❑ Yes ❑ No ❑ Health ❑ Vision ❑ Dental
17 Was the person insured by an employer in the last 90 days? If yes, check the main reason why insurance stopped and give the date it stopped.	❑ Yes ❑ No ❑ Lost job or changed job status ❑ Moved and no insurance available ❑ Employer ended benefits to all employees or certain categories of employees ❑ COBRA coverage ended ❑ Death, legal separation, or divorce ❑ Other __________ __________ / / MO DAY YEAR	❑ Yes ❑ No ❑ Lost job or changed job status ❑ Moved and no insurance available ❑ Employer ended benefits to all employees or certain categories of employees ❑ COBRA coverage ended ❑ Death, legal separation, or divorce ❑ Other __________ __________ / / MO DAY YEAR	❑ Yes ❑ No ❑ Lost job or changed job status ❑ Moved and no insurance available ❑ Employer ended benefits to all employees or certain categories of employees ❑ COBRA coverage ended ❑ Death, legal separation, or divorce ❑ Other __________ __________ / / MO DAY YEAR	❑ Yes ❑ No ❑ Lost job or changed job status ❑ Moved and no insurance available ❑ Employer ended benefits to all employees or certain categories of employees ❑ COBRA coverage ended ❑ Death, legal separation, or divorce ❑ Other __________ __________ / / MO DAY YEAR
18 **SECTION 3** Monthly Countable Income *(if any)*	$ From where?	$ From where?	$ From where?	$ From where?

19 Gross (before taxes) monthly countable income of the applicant and the other adult in the household.	Applicant $________ From where? Relationship to person(s):	How often Received? ❑ Once every week ❑ Every two weeks ❑ Twice a month ❑ Every month	Other Adult $________ From where? Relationship to person(s):	How often Received? ❑ Once every week ❑ Every two weeks ❑ Twice a month ❑ Every month

20 Monthly Income Deductions (For each working parent, we will deduct up to $90 for work-related expenses)	Monthly childcare expenses you pay for children under age 2. The maximum amount allowed is $200	$
	Monthly childcare expenses you pay for children age 2 and over. The maximum amount allowed is $175	$
	Monthly disabled dependent care expenses you pay. The maximum amount allowed is $175	$
	Monthly court ordered alimony/spousal support you pay.	$
	Monthly court ordered child support you pay.	$
21 Is the applicant or anyone else in the home pregnant?	❑ **Yes** ❑ **No** **If Yes, please list name** ____________________	

- **See the *Household Information Instructions* for a list of what income counts and acceptable income documentation.**
- **You must include a birth certificate for each person you want to add who is a U.S. citizen or national (within 60 days) and documentation of birth for a newborn (within 30 days of birth) or;**
- **Proof of immigration status for each person you want to add (within 30 days)**

I, the applicant, certify that the information provided is true and correct. I understand that adding additional family members may result in a higher monthly premium.

Applicant Signature X______________________________ **Date:**_______________

22 **Authorization to Forward to Medi-Cal**

If this person/child is ineligible for Healthy Families, I request that this form be forwarded to the county and treated as a Medi-Cal application. I declare under penalty of perjury that the information on this form is true and correct to the best of my knowledge and belief. Please provide Social Security numbers of persons/children applying for full scope Medi-Cal benefits. **Applicant Signature X**______________________________ **Date:**_______________